JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

REPORT TO THE 2009 REGULAR SESSION OF THE 2009 GENERAL ASSEMBLY

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JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES
State Legislative Building
Raleigh, North Carolina 27603

Senator Martin Nesbitt, Co-Chair *Representative Verla Insko, Co-Chair*

March 1, 2009

TO THE MEMBERS OF THE 2009 GENERAL ASSEMBLY:

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services submits this report for your consideration.

Respectfully,

_____ _____

Sen. Martin Nesbitt, Co-Chair Rep. Verla Insko, Co-Chair

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PREFACE

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) is established in Article 27 of Chapter 120 of the General Statutes. The LOC is charged with continually examining system-wide issues that affect the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues related to governance, accountability and service quality.

The Committee consists of sixteen members, eight appointed by the President Pro Tempore of the Senate and eight appointed by the Speaker of the House of Representatives. The members appointed by the President Pro Tempore must include all of the following: at least two members of the Senate Committee on Appropriations, the Chair of the Senate Appropriations Committee on Human Resources, and at least two members of the minority party. The members appointed by the Speaker of the House must include all of the following: at least two members of the House Committee on Appropriations, the Co-Chairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, and at least two members of the minority party. Advisory members may also serve on the Committee. The Co-Chairs for 2008-2009 are Senator Martin Nesbitt and Representative Verla Insko.

COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) met seven times during the 2008-2009 interim. Following is a summary of the Committee's proceedings. Detailed minutes and information from each Committee meeting are available in the Legislative Library.

August 26, 2008

The LOC convened its first meeting of the interim on August 26, 2008 at 10:00 A.M. in Room 643 of the Legislative Office Building. Representative Verla Insko, Co-Chair, called the meeting to order and welcomed returning members, new members, and guests.

Staff members Andrea Poole, Fiscal Research Division, and Shawn Parker, Research Division, presented a review of 2008 legislative actions.

Gann Watson, Bill Drafting Division, and Denise Harb, Fiscal Research Division, discussed community support services. Ms. Harb summarized legislative actions taken to improve and strengthen fiscal oversight for community services. Ms. Watson discussed changes to the current Medicaid appeals process.

Dr. William Lawrence, Acting Director, Division of Medical Assistance (DMA), Department of Health and Human Services (DHHS), reported on the Division's actions and recent spending on Community Support Services.

Andrea Poole, Fiscal Research Division, discussed the State's psychiatric hospitals. Ms. Poole summarized expansions and reductions in the budget and reviewed legislative and statutory changes.

Dr. Mike Lancaster, Co-Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS), DHHS, gave an update on the State's psychiatric hospitals including Broughton Hospital, Cherry Hospital, and Central Regional Hospital.

Shawn Parker, Research Division, reported on LME administration and reviewed changes from the 2008 legislative session.

Leza Wainwright, Co-Director, Division of MH/DD/SAS, DHHS, discussed LME performance and reviewed the guidelines LMEs must meet to qualify for single stream funding.

Denise Harb, Fiscal Research Division, summarized legislative actions relating to crisis services.

Next, Ms. Wainwright reported on crisis services on behalf of the Division. Ms. Wainwright said that the goal of the crisis system is to provide a prompt response to emergency situations and that to be effective, all the components of

the system must work together. She then reviewed new components, including mobile crisis teams, respite beds, and walk in crisis clinics.

Denise Harb, Fiscal Research Division, discussed CAP-MR/DD Tiered Waivers. Ms. Harb reviewed legislation including: a) a directive for DHHS to implement the tiered CAP waiver program; b) the creation of four tiers; c) a requirement for DHHS to review, on a case by case basis, tier funding exceeding $100,000; and d) a directive for DHHS to implement a plan to increase Piedmont Behavioral Health slots to the statewide average.

Ms. Wainwright gave an update on DHHS actions regarding CAP-MR/DD Tiered Waivers and reported that two new waiver applications were submitted to CMS on August 1, 2008. Common elements of Tiered Waivers include person centered planning, quarterly waiver slots, deadlines for providers, and risk assessment. Priority is given to individuals leaving State developmental centers, people leaving Piedmont Behavioral Healthcare catchment areas who were participating in Innovations, and individuals served through the Money Follows the Person grant. Ms. Wainwright then reviewed the supports waiver and the comprehensive waiver.

Finally, Ms. Harb reported on MH/DD/SA System Indicators.

September 25, 2008

The LOC convened its second meeting of the interim on September 25, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building. Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests.

Daniel Hahn, Executive Director of the Alamance-Caswell-Rockingham LME, discussed the challenges facing the MH/DD/SA system from a local perspective.

Next, David Swann, representing Crossroads Behavioral Healthcare LME (Iredell, Surry, and Yadkin counties), gave an overview of mental health services in rural North Carolina. Mr. Swann mentioned several challenges for LMEs in rural areas: the recruitment and retention of professional staff; fewer providers due to a lack of volume; the additional costs of providing services to rural areas; and limited public transportation.

Dr. Jim Osberg, Chief of State Operated Services, Division of MH/DD/SAS, DHHS, gave an update on the State psychiatric hospitals including certification and reimbursement status for each facility.

Dr. William Lawrence, Acting Director of the Division of Medical Assistance (DMA), DHHS, discussed the suspension of Medicaid benefits and Medicaid enrollment for recipients in institutions for mental disease or those incarcerated.

Dr. Lawrence also reviewed a chart on community support expenditures. Dr. Lawrence explained that DMA has submitted an amendment to the State Plan

and is waiting on approval from the Centers for Medicaid and Medicare Services (CMS) before updating the State Plan with legislative changes including: tiered rates for community support and requiring every community support provider organization employ a licensed clinician.

Senator Nesbitt, Co-Chair, then reviewed the MH/DD/SA System Indicators chart. He noted that the placement of people in local beds result in a reduction in the 1-7 day admissions in the State psychiatric hospitals.

Leza Wainwright, Co-Director for the Division of MH/DD/SAS, discussed Traumatic Brain Injury (TBI) Services. Ms. Wainwright explained the difference between traumatic and non-traumatic brain injury. Ms. Wainwright also reviewed the types of services available in North Carolina under Medicaid and State funded services.

Flo Stein, Chief of Community Policy Management, Division of MH/DD/SAS, DHHS, gave an overview of the funding provided to expand the regional substance abuse initiative: Cross-Area Service Programs (CASP).

Next, Trish Hussey, Executive Director of Freedom House Recovery Center, described the Center; the 5 district outpatient clinic sites in Orange, Person and Chatham counties; and the long-term residential homes in operation in Durham County.

Senator Nesbitt, Co-Chair, then called on members of the audience to come forward for the public comment period of the agenda.

October 16, 2008

The LOC convened its third meeting of the interim on October 16, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building. Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests.

Dr. Hunter Thompson, Medical/Clinical Director of Albemarle Mental Health Center (AMHC) addressed the LOC and expressed his concern over the reform efforts by the State. Dr. Thompson explained that AMHC developed a partnership with the local hospital in Elizabeth City, establishing a dedicated crisis unit with a Telemedicine service that allows doctors to perform assessments to all regions of the catchment area. Next, Charlene Allen, Finance Officer for AMHC, discussed budgetary issues for AMHC.

Dr. Janis Nutt, Area Director, Johnston LME, addressed the successes and challenges in Johnston County during mental health reform. Dr. Nutt gave a brief history, reviewed the 5 basic services provided, and explained how strong community collaborations and partnerships contributed to the strength of the LME.

Next, Dr. Shealy Thompson, Quality Management Team Leader, Division of MH/DD/SAS, DHHS, provided a matrix summarizing LME performance measures that are tracked and reported quarterly in the Community Systems Progress Report.

Dr. Jim Osberg, Chief of State Operated Services, Division of MH/DD/SAS, DHHS, gave an update on the State ADATC facilities and on the State psychiatric hospitals including certification and reimbursement status for each hospital.

Leza Wainwright, Co-Director, Division of MH/DD/SAS, DHHS gave an overview of the changes in Community Supports for Medicaid and State funded services including the number of people receiving services and the types of services received.

Tara Larson, Acting Director of the Division of Medical Assistance (DMA), DHHS, presented information on the appeals process for Community Supports. Ms. Larson also informed the LOC that expenditures for Community Supports for the first quarter this year were down to $139 million compared to the first quarter last year of $262 million, a difference of 47%.

Valerie Bradley, President of Human Services Research Institute, presented a review and recommendations from a stakeholders group in the developmental disabilities field concerned about the direction of the system. She discussed the challenges facing North Carolina and other states including: the aging population, the growing waiting lists for home and community based services, and the need to strengthen case management.

Next, Leza Wainwright addressed the issue of family members providing CAP-MR/DD services. Ms. Wainwright explained that the topic of family caregivers as paid providers of the CAP-MR/DD waiver has been a topic of interest since October 2006.

Cynthia Vester from the NC Consumer, Advocacy, Networking and Support Organization (NC-CANSO), reported that NC-CANSO was created as a result of legislation (H.B. 1888) that established an independent statewide organization formulated to facilitate communication and support among people with MH/DD/SA issues. Ms. Vester reviewed NC-CANSO's accomplishments during the past year and respectfully requested additional funding for the next session.

November 20, 2008

The LOC convened its fourth meeting of the interim on November 20, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building. Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests.

Dr. Shealy Thompson, Quality Management Team Leader for the Division of MH/DD/SAS, reviewed the LME performance measures matrix presentation. Dr. Thompson explained that the matrix provides a summary of State and LME performance on 21 different measures published quarterly.

Al Huntoon, owner of Catalyst Consulting Services, management consultant for Kenan Flagler Business School, and managing director of the Mental Health Leadership Academy (MHLA), addressed the LOC. With Mr.

Huntoon was James Johnson, Faculty Director. Mr. Huntoon discussed the Business School's statewide initiative to train senior LME staff, Division staff, and community partners. The initiative provides resources and expertise to the LMEs to help manage money, people, information, and partnerships. Mr. Huntoon provided an overview of the last year at the Leadership Academy which included: program design, goals, evaluation methodology, and findings.

Three LMEs discussed the benefits of working with MHLA:

- Mike Watson, Sandhills Center LME (Sandhills), summarized Sandhills' Capstone project. According to Mr. Watson, the MHLA provided an opportunity to look at particular issues in the community and tailor projects effectively. Mr. Watson gave a brief description of the Sandhills hospital transition program, explained the goals of the program, and discussed the program's financial model.
- Don Scott, Five County Mental Health Authority LME (FCMHA), summarized FCMHA's Capstone project. The FCMHA project came from a local business plan that recognizes and consistently accesses high-performing providers through published performance criteria and outcomes.
- Anna North, Quality Improvement Director, Eastpointe LME (Eastpointe), discussed Eastpoint's Capstone project, Walk-In Crisis Centers. Ms. North explained the goals for the project were to reduce bed day utilization, reduce the number of State hospital admissions, increase the use of respite, increase the use of private hospitals, and increase the use of walk-in crisis facilities.

Mr. Hank Debnam, Area Director, Cumberland County LME, provided statistical information about Cumberland County as well as information on the successes, challenges, and needs of the county. Mr. Debnam mentioned several successes including: the establishment of a Crisis Intervention Team (CIT) program for local law enforcement personnel; the implementation of a system of care for children; and the expansion of housing resources for persons with disabilities. Several of the needs mentioned by Mr. Debnam included: stable funding, transportation resources for rural areas, and resources for relocating military families.

Mr. John Hardy, Area Director, Mental Health Partners (MHP) serving Catawba and Burke counties, discussed the importance of stability in the system and the importance of community relationships. Mr. Hardy stressed the need for a standardized electronic medical record and a standard IT system. He also suggested that there needed to be more current regulations regarding guardianship.

Leza Wainwright, Co-Director, Division of MH/DD/SAS, DHHS, reported on the status of the special provisions funded in the 2008.

Dr. James Osberg, Chief of State Operated Services, Division of MH/DD/SAS, DHHS, gave an update on the State psychiatric hospitals including the regulatory status of the hospitals.

December 18, 2008

The LOC convened its fifth meeting of the interim on December 18, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building. Senator Martin Nesbitt, Co-Chair, called the meeting to order and welcomed members and guests.

Dan Jones, Area Director from Onslow-Carteret Behavioral Healthcare (OCBHS), provided statistical information about Onslow and Carteret counties. Mr. Jones stated that to provide stability within the community, both counties have Walk-In Clinics with providers housed in Carteret County. Mr. Jones stated that OCBHS has been working closely with local hospitals to obtain crisis beds.

Dr. Dana Hagele and Dr. Lisa Amaya-Jackson, Co-Directors of the North Carolina Child Treatment program, discussed a mental health pilot in the northeastern part of the State for children and adolescents exposed to extreme trauma. According to Dr. Hagele, the program is based on a public health approach and has had excellent outcomes. In most cases treatment lasts no longer than 4 months. She explained that the pilot project covered 28 counties and was initially funded $1.8 million for 3 years, ending in June 2009. Dr. Hagele stated that an annual recurring legislative appropriation of $2 million dollars was needed to continue the program.

Senator Nesbitt reviewed several items on the MH/DD/SA System Indicators sheet for November that is prepared monthly by staff.

Next, Leza Wainwright, Co-Director of the Division of MH/DD/SAS, gave an overview of residential options for persons with developmental disabilities. Ms. Wainwright discussed the number of people with developmental disabilities currently served in the public sector. Ms. Wainwright then reviewed a chart showing the types of residential facilities available and the number of beds in those facilities.

Next, Carol Donin from DHHS State Operated Services presented an overview of the three State-operated developmental centers: Murdoch, Caswell, and Riddle. Ms. Donin provided general data about the residents and explained the special programs offered at the centers including the PATH program, BART, the STARS program, and the MR/MI program.

After lunch, Ms. Wainwright gave a presentation on community ICF/MR facilities, DD Group Homes, and Adult Care Homes serving consumers with developmental disabilities, that provided general data on each type of facility.

Rose Burnette, Tiered Waiver Project Manager, Division of MH/DD/SAS, presented a brief summary of the CAP-MR/DD Supports Waiver and the Comprehensive Waiver. According to Ms. Burnette, each waiver has an annual per-consumer service dollar cap ($17,500 for the Supports Waiver and $100,000 for

the Comprehensive Waiver); however, a consumer is not automatically entitled to the maximum service level. Ms. Burnette explained that the services and supports for both waivers are based on the needs of the individual outlined in their Person Centered Plan.

Ms. Burnette then reviewed a new service, Home Supports. She explained that the Home Supports, only available with the Comprehensive Waiver, provides habilitation and personal care services.

Dr. Michael Lancaster, Co-Director, Division of MH/DD/SAS, provided a brief update on the State psychiatric hospitals.

January 14, 2009

The LOC convened its sixth meeting of the interim on January 14, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building. Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests.

Leza Wainwright, Director, Division of MH/DD/SAS, provided an update on Albemarle LME. According to Ms. Wainwright, a review team of DHHS staff found significant problems in 4 key local management functions: finances, provider relations, customer services, and the utilization management of state funds. Ms. Wainwright stated that the LME board has decided to terminate the director effective February 1, 2009 and has appointed an interim director.

Representative Insko introduced the new Secretary of Health and Human Services, Lanier Cansler. Secretary Cansler spoke briefly about issues facing the system and the development of community capacity to reduce pressure on State facilities. Secretary Cansler also expressed concern over the care of patients in the State facilities and stated there would be a clear policy of zero tolerance for the neglect or abuse of patients.

Pam Silberman, President, North Carolina Institute of Medicine (NCIOM), presented the final report of the Taskforce on Substance Abuse Services. She explained that in 2007 the General Assembly asked the NCIOM to study the substance abuse system for the State with an interim report due in 2008, and a final report due in 2009. Suggested recommendations of the Taskforce focused on filling in gaps to create a comprehensive substance abuse services system ranging from prevention to recovery support.

John Corne, Chairman, Commission on MH/DD/SAS, reported on deaths in State facilities. The Commission was charged with studying the death reporting statutes and any additional reporting requirements or modifications to existing rules or procedures.

Dr. Carol Ripple, Program Evaluation Division, reported on the results of an evaluation of services delivered by the Division of MH/DD/SAS. Dr. Ripple explained that the report provided an independent analysis of the outcomes experienced by consumers who were hospitalized at least once for mental health or substance abuse problems.

Rhett Melton, Area Director, Pathways LME, presented an overview of the LME including: highlights of local accomplishments during reform, significant challenges, and suggestions for improvements to the mental health system.

Judy Truitt, Area Director, Orange Person Chatham LME (OPC), reviewed data on county funds allocation, staff profiles, initiatives, and housing.

Karen Salacki, Area Director, the Beacon Center, discussed hospital admissions and bed day utilization wit in the LME's catchment area. Ms. Salacki reviewed pre-admission, acute admission, long term admission, and post-discharge strategies utilized by the LME to reduce hospital admissions and bed day utilization in the State psychiatric hospitals.

Leza Wainwright, Director, Division of MH/DD/SAS, DHHS, gave an update on the expenditure of service dollars.

Dr. Jim Osberg, Chief of State Operated Services, Division of MH/DD/SAS, DHHS, gave an update on the State psychiatric hospitals including certification and reimbursement status for each facility.

February 17, 2009

The LOC convened its seventh meeting of the interim on February 17, 2009, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Mr. Carl Noyes provided an update from the State Consumer and Family Advisory Committee.

Flo Stein, Chief of Community Policy Management, Division of MH/DD/SAS, DHHS, gave a progress report on the Outpatient Involuntary Commitment Workgroup. The Workgroup….

LOC staff presented a review of the draft report, the Committee adopted the report as amended.

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INTRODUCTION

The basic tenant of Mental Health Reform, enacted in S.L. 2001-437, is that consumers are best and most effectively served when the services they need are delivered in a community setting. Moreover, the system must be:

- participant-driven
- prevention-focused
- recovery-oriented
- State directed and locally managed
- cost-effective
- based on recognized best practice treatments, and self-determination of outcomes.

Every year since 2001, the General Assembly has enacted legislation to support the reform and restructuring of the State's system for delivering MH/DD/SAS services. These reform efforts have aimed to increase local management of the system, decrease reliance on State institutions, encourage the use of community-based best practice treatments, increase consumer involvement in the system, allow access to a range of qualified providers, and hold system providers and managers accountable to both State and local government. Through provisions it has enacted, the General Assembly has directed the Secretary of the Department of Health and Human Services and the Division of MH/DD/SAS to administer the system's reform. Oversight of reform efforts has been provided by the General Assembly and its Joint Legislative Oversight Committee on MH/DD/SAS (LOC).

To continue to work toward system reform, the LOC recommended and the 2008 session of the General Assembly approved significant increases in funding and numerous modifications to existing MH/DD/SAS statutes. This report builds on ideas proposed last year and emphasizes the need to fully fund current programs while also supporting new initiatives vital to successful system reform.

COMMITTEE FINDINGS AND RECOMMENDATIONS

FINDING ONE: SYSTEM ADMINISTRATION

The Economic Crisis is straining our already-fragile provider network.
The economic crisis our country and State is experiencing has imposed serious financial difficulties at every level of our State's economy. One level is the resulting credit-crunch, significantly reducing the extension of new credit, and increasing the number of lenders requiring immediate repayment of loans. This impact is creating severe cash-flow problems for local governments, including local management entities, and for providers. Cash-flow problems have a negative impact on the availability of services.

It is the State's responsibility to support the LMEs in order to maintain and improve the system's functioning.
Local Management Entities (LMEs) are responsible for managing and overseeing the public system of Mental Health, Developmental Disabilities, and Substance Abuse Services at the community level. The State through the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Department) is responsible for LME oversight, to build and support state-wide system uniformity, to ensure LME administration is adequate and to enforce the law. The ability of the LME to function effectively is vital to reform's success.

LMEs must develop and share creative solutions; The Department can encourage innovation by pursuing statewide Medicaid waivers.
During the 2008-2009 interim, the LOC continued its practice of hearing presentations from LMEs. Including presentations heard in recent interims, the LOC has now received advice and recommendations from all twenty-four LMEs. Based partially on these presentations, the LOC realizes that LMEs need a forum for learning from each other. Individual LMEs develop creative solutions to difficult, commonly-faced problems, and can be a good source of lessons, ideas and innovations for other LMEs. Additionally, as a second method to improve innovation and flexibility, the Department of Health and Human Services may pursue statewide Medicaid waivers, including 1915(b)(c) waivers.

The State and the LMEs must cooperate to foster the development and success of the provider network.
Providers maintain that different LMEs use different forms for the same purpose, which makes work difficult and unnecessarily time-consuming for providers who serve consumers in multiple LMEs. In addition, many LMEs have or are in the process of developing varying electronic systems that cannot necessarily communicate with one another; this can compromise or delay the continuity of care for consumers who move from one area of the State to another.

Over-expansion of LME catchment areas diminishes local oversight and control.
Consumers are best served in the community, and the oversight for those services should be in the community as well. Mergers that expand an LME's catchment area by hundreds of square miles or by additional, far-reaching counties take away from local oversight and control. Legislation in 2008 limited mergers, with some exception, until January 2010. The LOC recommends extending the prohibition until June 1, 2010, while allowing for mergers of LMEs that are contiguous and that are approved by each Board of County Commissioners for all member counties.

Utilization Management should be returned to LMEs.
LME's core functions, as defined by General Statute 122C-115, include utilization management, utilization review, and determination of the appropriate level and intensity of services to ensure that services are needed and appropriately provided. In recent years these functions have been transferred to an outside vendor. The 2008 General Assembly directed the Department to return utilization management to LMEs representing at least 30% of the State's population. As a next step, the Department should return utilization management to LMEs representing at least 60% of the State's population by January 1, 2011. To achieve this greater proportion, LMEs must be allowed to contract with one another to perform this function, notwithstanding prohibitions on LME mergers. Also the Department should be permitted to extend its contract with an outside vendor until September 30, 2010.

State dollars appropriated to LMEs for direct services must be fully spent
Despite continuing demand for State-funded services, the 2008 LOC report noted that State dollars appropriated for direct services were under-spent. To help LMEs use these dollars for services to consumers in need, the 2008 General Assembly took multiple actions, including requiring the Department to provide non-single-stream-funded LMEs with some funds at the very beginning of the fiscal year and directing the Department to simplify the State Integrated Payment and Reporting System. Additionally, the General Assembly directed the Department to consult with LMEs and to report to the LOC about barriers to spending State service dollars. The Department recommended several strategies to increase expenditures, including that services be charged against the month in which they are provided, so that State funds used to pay for services rendered in May and June would be reconciled to the correct fiscal year; that providers should be required to submit bills within a certain number of days, and that the Department should reallocate unspent service dollars at mid-year towards those LMEs who appear most likely to be able to spend them.

Tobacco is a gateway drug to future substance abuse.
Data collected by the Surgeon General, the CDC, and other research organizations has long demonstrated that cigarette smoking and the use of other tobacco products, as well as exposure to second-hand smoke, is harmful to virtually all of the body's vital organs. In addition to the physical conditions and illnesses caused by smoking, taxpayers bear a substantially higher cost in health care premiums and treatment to provide health care for tobacco-related illnesses. It has also been documented that nicotine is a gateway drug to the addiction of other drugs. Many states have implemented no-smoking laws to protect the health of children and adults by prohibiting the use of tobacco products in public places. In the 2007-2008 legislative session, the North Carolina General Assembly enacted laws prohibiting smoking in government buildings and vehicles and permitting local governments to do the same. This policy has encouraged the introduction in the 2009-2010 regular session of at least one bill extending the smoking prohibition to places of employment and all but a few public places, as well as authorizing local governments enact ordinances that are more restrictive than State law.

RECOMMENDATIONS: SYSTEM ADMINISTRATION

1. Direct the Department to continue to implement its plan to return the service authorization, utilization review, and utilization management functions to LMEs by increasing the number of LMEs performing these functions to encompass at least sixty percent (60%) of the State's population by January 1, 2011. The Department shall designate by July 1, 2010, which LMEs are authorized to perform these functions. Also, prohibit the Department from contracting with an outside vendor for service authorization, utilization review, or utilization management functions, or otherwise obligating the State for these functions beyond September 30, 2010.

2. Clarify that contracts between LMEs for service authorization, utilization review, and utilization management functions do not constitute a merger or consolidation.

3. Prohibit the Secretary to take any action that would force or otherwise result in the merger or consolidation of LMEs, prior to June 1, 2010. Allow contiguous LMEs on their own initiative, to merge or consolidate under the following circumstances: (i) an LME does not meet the catchment area requirement of G.S. 122C-115, or (ii) the LMEs have received approval from each board of county commissioners within the affected multi-county areas.

4. Appropriate funds to the Department to fund the Mental Health Leadership Academy. Also, direct the Department, in consultation with the Mental Health Leadership Academy, to provide for training and information sharing opportunities on innovative and effective practices among LMEs.

5. Authorize the Department to apply for 1915(b) and (c) waivers to provide LME flexibility in management functions.

6. Direct the Department to create an "Incurred but Not Reported" category of funds such that services are paid based on the actual date of service rather than the date when the invoice is received. Categories created by the Department should be subject to approval by the Office of State Budget and Management

7. Permit the Department to require providers to bill LMEs for state-funded services within 60 days of the occurrence of the service.

8. Permit the Department to create a formal mid-year process by which to reallocate State service dollars among LMEs.

9. Remain mindful of the impact on services to people most in need of them, our vulnerable populations, in requesting additional funds from the federal government and in considering budget cuts at the State level.

10. Increase the tax on cigarettes to a level that reflects the national average and direct the resulting revenue towards prevention programs and reducing health care expenditures to treat lung disease, cancer, addiction disorders and other serious illnesses and conditions brought on by long-term tobacco use and exposure to second-hand smoke.

FINDING TWO: STATE-OPERATED AND STATE-LICENSED FACILITIES

Consumers served in residential settings are entitled the assurance that treatment they receive is in a safe environment free of neglect and abuse.
In cases of abuse or neglect resulting in a resident's death, the issue must be resolved expeditiously and the aggrieving party must be held accountable. To encourage transparency, the LOC recommended and the General Assembly enacted a requirement that all deaths occurring in State institutions listed in Part 5 of Article 4 in Chapter 122C of the General Statutes be reported to the State Medical Examiner to determine if further investigation into the cause of death and circumstances surrounding the death is necessary. Despite this measure, there are questions regarding compliance with this requirement. Moreover there are hundreds of residential facilities licensed under Chapter 122C that remain outside the scope of the new law.

The Department must maintain a database that contains records of any death that occurs in a facility either operated or licensed under the provisions of Chapter 122C.
The database should be recorded and maintained in a database which would include the facility name, the time and date of the death, and circumstances surrounding the death. While it is important for full public disclosure to improve oversight and accountability, access to these records is intended to provide relevant details about the death but not compromise the patient's right to privacy. In order to improve compliance, all direct care and administrative employees must be aware of the procedures and legal requirements to be followed when a death occurs within their facility.

The General Assembly should strengthen the residency requirements to qualify for State-County Special Assistance.
The LOC in cooperation with the North Carolina Study Commission on Aging has studied the issue of consumers with mental illness residing in adult care homes. An influx of these consumers can strain the ability of the homes to provide adequate care, and also strain the limited resources of LMEs, who are responsible for coordinating care for individuals that reside within their catchment. The LOC supports increasing the residency requirements to qualify for special assistance.

An Outpatient Commitment from State Psychiatric Hospitals should be for a period of not less than 180 days.
On multiple occasions this interim, the Committee heard concerns regarding methods of tracking and following up care for patients discharged from the State psychiatric hospitals. The State psychiatric hospitals, where appropriate, utilize the involuntary outpatient commitment process as part of its discharge planning and have found that applying the current statutory provisions has not had the desired results. Specifically, the hospitals have experienced difficulties with the ability to track post-patient care resulting in increased recidivism rates. As reported to the Committee, studies show outpatient commitment of less than 180 days actually increased hospital use and outpatient commitments are most effective when combined with regular mental health services. Treatment non-adherence detrimentally impacts patients and burdens the mental health, criminal justice, and social welfare systems. Effective and appropriate outpatient involuntary commitments can reduce violence, victimization, family strain, arrests, and improve medication adherence and quality of life.

The General Assembly should appropriate funds for a Residential Step Down Unit for consumers at the Murdoch Center's BART Unit.
The Murdoch Center – one of the State's three residential centers for developmental disabilities – offers a 12-bed residential program called the Behaviorally Advanced Residential Treatment (BART), for young men between the ages of 16 and 25 who have mild mental retardation, other developmental disorders, or extremely challenging behavior. Many of the residents have autism without severe to profound intellectual disability. The Murdoch Center has successfully treated many of these consumers in the BART unit, but needs a residential step-down unit to help consumers transition out of the Murdoch Center and into the community. Currently, the BART unit receives more referrals than it can accept, while some consumers at the BART unit could live in the community if they received appropriate and adequate transition supports including a step-down unit. The LOC supports funding for a step-down unit for these consumers.

The Department should oversee consumer access to privately-operated ICFs-MR.
Oversight by the Department is essential in order to ensure that consumers are served at the appropriate level of care. A screening tool implemented by LMEs would provide this oversight, would separate screening from service delivery, and would encourage LMEs to be involved in actively managing the consumers in the LME's catchment area who are in ICFs-MR.

RECOMMENDATIONS: STATE-OPERATED AND STATE-LICENSED FACILITIES

1. Direct the Department to create and maintain a database of all deaths that occur in facilities governed by Chapter 122C of the North Carolina General Statutes. The database shall include the name and location of the facility, the time and date of the death, and relevant details relating to the death.

2. Direct the Department to provide training on the statutory and rule provisions relating to death reporting to all administrative and direct care employees who work in State Operated facilities.

3. Under the State Medicaid program, individuals seeking to qualify for Medicaid must provide certain documentation as evidence of residency of North Carolina. Likewise, to address significant increases in county expenditures for State-County Special Assistance, the General Assembly should change the residency requirement for eligibility for special assistance from 90 days to 180 days to decrease the likelihood of persons moving to North Carolina from border states solely for the purpose of qualifying for State County Special Assistance.

4. The Department of Health and Human Services should work with the Administrative Office of the Courts to implement a pilot program that would authorize judges to order outpatient commitment for a minimum of 180 days for qualifying individuals. The purpose of the pilot program would be to determine whether extended outpatient commitment would result in reduced recidivism and greater tracking and services for the outpatient committees. The General Assembly should appropriate the funds necessary to support the pilot program for the 2009-2011 fiscal - biennium.

5. Appropriate $300,000 in recurring funding and $1,500,000 in non-recurring funding to create a step-down unit for consumers served in the Murdoch Center's BART unit.

6. The Department of Health and Human Services shall identify a screening tool that will be used by LMEs to determine how consumers currently access services provided by ICFs-MR. This will help ensure that the services are provided to consumers at the appropriate level of care.

7. The General Assembly should continue funding the Housing Initiative (formerly the "Housing 400 Initiative") by appropriating $10 million to the Housing Trust Fund and $2.5 million to the Department for recurring

operating support for approximately 500 units. By providing stabilizing services and supports to prevent crises from occurring, appropriate housing will reduce the need for State Psychiatric hospitals in the long-term.

8. The General Assembly should appropriate funds to DHHS to increase salary ranges for the Division, including State psychiatric hospital personnel, to help with recruiting and retaining qualified staff.

FINDING THREE: COMMUNITY-BASED SERVICES

The Department should apply for waivers for Traumatic Brain Injury services
North Carolina's FY 2008-09 budget includes $2.7 million in dedicated State TBI funding, of which $1 million was newly-appropriated in the 2008 legislative session. However, there is concern that State dollars are insufficient to serve the TBI population. According to the Department, national statistics from the federal Centers for Disease Control and Prevention suggest that approximately 0.2% of the population is living with TBI (or approximately 18,500 North Carolinians). However, according to Department estimates, the State in 2008 served only 302 people with TBI in the community with state funds and 13 people with TBI in state facilities.

As of 2007, twenty-three states operated a special Home and Community Based Services Medicaid waiver for individuals with TBI. Typically, a TBI waiver is used to allow consumers to waive an institutional level of care (e.g., nursing home care) and to allow the State to establish asset and income levels for eligibility that differ from the State's standard Medicaid program.

Local inpatient psychiatric capacity must be fully funded and expanded.
Although the benefits of community-based care are many, State hospital usage – the most expensive type of care for the State – remains high, tying up resources that could be used to serve more consumers in less-expensive settings. Because Medicaid will not pay for inpatient care at a stand-alone psychiatric hospital for consumers aged 18-64, research by the North Carolina General Assembly's Program Evaluation Division indicates that the State pays 81% of the cost of care for adults in State hospitals, but only 41% of the cost of community-based care.

It is the State's policy that beds in the three State-run psychiatric hospitals are intended for long-term admissions for consumers who cannot be adequately or safely treated in the community, including in community general hospitals with psychiatric beds. However, as of December 2008, just under 45% of State hospital admissions, on average, were for seven days or less. These consumers should be served in their communities, not at State hospitals. The FY 2008-09 budget included partial-year funding to increase community capacity to achieve this goal.

Regionally-Purchased Locally-Hosted Substance Abuse Services are an effective use of State dollars.
In the 2007 legislative session, the General Assembly directed the Department to spend $6 million of substance abuse dollars on regionally-purchased, locally-hosted substance abuse services (often called Cross Area Service Programs, or CASP); the General Assembly in 2008 increased that directive to $8 million. The Department reported to the LOC that it used these funds to increase community capacity for adult substance users and pregnant women and to increase the capacity of residential programs with a vocational component. The LOC finds that CASP is an appropriate and effective use of substance abuse dollars.

Fully fund the CAP-MR/DD Waiver's Tier 1 slots; Plan for future Tiers.
The purpose of tiered CAP-MR/DD waivers are to assure that individuals receive the services they need (no more and no less) and to manage the system's operation so that services are allocated equitably, with the highest-cost services and/or those delivered at the highest level of intensity going to those with the most significant needs. The 2008 General Assembly directed the Department to develop and implement four CAP-MR/DD tiers. To date, the Department has developed and implemented Tier 1 and Tier 4, and intends to carve Tiers 2 and 3 out of Tier 4.

Before the Department moves forward with the development, submission of proposal to CMS and implementation of a four-tiered waiver, the LOC needs to understand the Department's plan to assure that the four tiered waiver meets the purposes listed above. The LOC needs to see what services are assigned to each of the four tiers, at what intensity level and at what range of costs. The LOC is interested in having the CAP-MR/DD Waivers designed to assure that individuals receive the services they need with services and costs consistent with the intensity of their needs. This also has as a requirement that the development of a formula, based on a reliable, valid, statewide assessment of intensity of need, be administered to all persons eligible for DD services that assigns individuals to tiers based on measured intensity of need. In addition to waivers the General Assembly should appropriate sufficient funds to fully fund implementation of Tier 1 of the CAP-MR/DD program.

The Department must support and facilitate workforce development in the field of Developmental Disabilities

The North Carolina Council on Developmental Disabilities convened a workgroup ("Looking Forward: a Summit on the Developmental Disabilities System in North Carolina") to develop recommendations concerning services and supports for consumers with intellectual and developmental disabilities, and their families. The Summit noted areas for improvement within the current system, including the need for a viable workforce. The LOC has reviewed the recommendations of the Summit and believes that the Department should establish statewide competency and values-based portable training and certification requirements for direct support workers, front-line supervisors and case managers. To do this, the Department needs a staff member with expertise in assessing workforce issues, who can serve as the project manager for implementing the Division's workforce development initiatives, particularly the recommendations identified in the *MH/DD/SAS Workforce Plan*.

The General Assembly should provide funds for the Department to continue participating in the "Money Follows the Person" demonstration grant

The Money Follows the Person Demonstration Project is a federally-supported initiative to help transition consumers out of nursing facilities, state psychiatric hospitals, and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR). The federal Centers for Medicare and Medicaid Services (CMS) provides a higher federal match for services for transitioned consumers. However, the enhanced federal match is not available for administration services, or for the first year (planning) of the Demonstration. For the remaining four years of the Project, the enhanced match is available for qualified home- and community-based services provided to each individual transitioned and is available for 12 months following transition. During the 2008 legislative session, the General Assembly appropriated funds for two FTE positions within the Division of Medical Assistance to implement the grant. The LOC supports providing the Department with the additional funding it needs to continue participating in the grant program.

The General Assembly should appropriate funds to scale up the Evidence-Based Mental Health Treatment for Children Pilot

The North Carolina Child Treatment Program is a pilot program serving children and adolescents who have been exposed to serious trauma, and their families. The program operates as a partnership between Duke and UNC and has been funded with $1.8 million in State and private funding. The pilot currently serves northeastern North Carolina by training licensed clinicians, linking traumatized

children and adolescents with trained clinicians, providing effective mental health treatment, paying for the treatment if needed, and providing ongoing clinical support to the clinicians. The LOC supports appropriating State funds to scale-up the pilot to provide statewide services.

The General Assembly should appropriate funds to advance recommendations of the NC IOM Substance Abuse Taskforce.

The 2007 General Assembly directed the North Carolina Institute of Medicine (NC IOM) to convene a taskforce to identify the continuum of services needed to treat substance abuse, including prevention, outpatient services, residential treatment, and recovery supports. The NC IOM found that addiction is a chronic disease that requires a recovery-oriented system of care throughout life and that therefore, it is necessary also to emphasize prevention and early intervention. The Taskforce provided the LOC with recommendations to improve substance abuse services in North Carolina; the LOC finds that funding is needed to advance several of the Taskforce's priority recommendations.

The NC IOM should study the availability of MH/DD/SA Services for military personnel

The LOC recognizes that as a State with a large military presence, North Carolina has many returning service personnel who have suffered a traumatic brain injury and/or who may have significant mental health and substance abuse needs. At the LOC's recommendation, the General Assembly in 2008 directed the Department to included veterans and their families as a target population for MH/DD/SA services; also, the Department has established the "Returning Support for Veterans Program" as a one-stop service where veterans and their families can receive all the information they need about available services. However, to assure that the available services are adequate, it is important to know how many service personnel are receiving services provided by the state, the nature of those services and the prevalence of unmet needs.

RECOMMENDATIONS: COMMUNITY-BASED SERVICES

1. Appropriate the necessary funds to the Department to establish a Workforce Development Specialist position within the Division of MH/DD/SAS.

2. Direct the Department to submit to the LOC by September 2009 a report about the tiered CAP-MR/DD waiver program. Specifically, the report must include:

    - The service array and intensity of CAP-MR/DD services for the two existing and two planned tiers;
    - How the relative intensity of need for each consumer will be determined and how this determination will be used to assign individuals into the tiers;
    - The criteria DHHS will use to select a valid assessment instrument and how the instrument will be administered;
    - Mechanisms to ensure operational accountability;
    - How the implementation of the tiers will lead to cost savings, how much cost savings are projected, and an estimate of how many additional consumers can be served within the current budget.

3. Appropriate funds for the 2009-2011 fiscal biennium to fully fund the implementation of Tier 1 of the CAP/MR-DD program.

4. Appropriate $10 million to the Department to implement one or more of the Substance Abuse Taskforce's priority recommendations, which included developing a comprehensive substance abuse prevention plan for use at the state and local levels; funding six pilot projects to implement county or multi-county comprehensive prevention plans; supporting efforts to reduce high-risk drinking on college campuses; and educating and encouraging healthcare professionals to use the SBIRT (screening, brief intervention, and referral to treatment) model promoted by the federal government.

5. Appropriate $2 million to the Department for the NC Child Treatment Program.

6. Direct the Department to allocate $10 million of its substance abuse funds to establish additional regionally-purchased, locally-hosted substance abuse programs.

7. Appropriate the necessary funds for the Department to continue to participate in the Money Follows the Person Demonstration Grant.

8. Direct the North Carolina Institute of Medicine (NCIOM) to conduct a study of State- and Medicaid-funded mental health, developmental disability and

substance abuse services currently available to active, reserve and veteran members of the military and National Guard and the need for increased State services to these individuals. The NCIOM shall submit a report of its findings and any recommended legislation to the Joint Legislative Commission on Governmental Operations and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services prior to the convening of the 2010 Regular Session of the 2009 General Assembly.

APPENDIX

Copies of the proposed legislation begin on the following page.